

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08275

8299

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH o. COUNTY <u>Frederick</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Frederick</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>				c. LENGTH OF STAY IN 1b <u>four</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Frederick Memorial Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Edith</u> Middle <u>S.</u> Last <u>Ahalt</u>				4. DATE OF DEATH Month <u>August</u> Day <u>20</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER-MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-26-1891</u>	
9. AGE (In years last birthday) <u>65</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Edward M. L. Lighter</u>				14. MOTHER'S MAIDEN NAME <u>Jennie Sanner</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Russel Ahalt, Middletown, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>5 hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>Aug 20</u> , 1956, to <u>Aug 20</u> , 1956, that I last saw the deceased alive on <u>Aug 20</u> , 1956, and that death occurred at <u>5:15 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. Elmer Harp</u> M.D.				ADDRESS (Street, city or town, state) <u>Middletown</u>		DATE SIGNED <u>8-21-56</u>	
PHYSICIAN'S NAME (Type) <u>J. Elmer HARP</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-23-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rehoboth Cemetery</u>		22d. LOCATION (City, town, or county) <u>Middletown</u> (State) <u>Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Gladbell G. Middletown</u> ADDRESS <u>Md.</u>				24. REC'D BY REGISTRAR <u>DATE 24 Aug 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Elizabeth G. Heck</u>	

CERTIFICATE OF DEATH

LAST NAME		FIRST NAME	
[Faint text]		[Faint text]	
MIDDLE NAME		AGE	
[Faint text]		[Faint text]	
SEX		RACE	
[Faint text]		[Faint text]	
DATE OF BIRTH		PLACE OF BIRTH	
[Faint text]		[Faint text]	
DATE OF DEATH		PLACE OF DEATH	
[Faint text]		[Faint text]	
CAUSE OF DEATH		MANNER OF DEATH	
[Faint text]		[Faint text]	
DATE OF BURIAL		PLACE OF BURIAL	
[Faint text]		[Faint text]	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS	
[Faint text]		[Faint text]	
DATE OF SIGNATURE		PLACE OF SIGNATURE	
[Faint text]		[Faint text]	

BUREAU V. 2

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DATE OF DEATH		PLACE OF DEATH	
[Faint text]		[Faint text]	
CAUSE OF DEATH		MANNER OF DEATH	
[Faint text]		[Faint text]	
DATE OF BURIAL		PLACE OF BURIAL	
[Faint text]		[Faint text]	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS	
[Faint text]		[Faint text]	
DATE OF SIGNATURE		PLACE OF SIGNATURE	
[Faint text]		[Faint text]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08276

8312

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY Frederick b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lewistown		c. LENGTH OF STAY IN b. 35 yrs.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lewistown		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mary Middle Elizabeth Last Bowers			4. DATE OF DEATH Month August Day 3 Year 1956			5. SEX female		6. COLOR OR RACE white	
7. MARRIED <input checked="" type="checkbox"/> NEVER-MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 18 1885		9. AGE (In years last birthday) 70 yrs.		10. IF UNDER 1 YEAR: Months 9 Days 25 Hours 55 Min.		11. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Fred. Co. Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Daniel Pearl			14. MOTHER'S MAIDEN NAME Annie			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. No		17. INFORMANT Wilbert L. Bowers		Address Lewistown, Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage DUE TO (b) Hypertension DUE TO (c) Arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic myocarditis			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that I attended the deceased from Feb. 2, 1956 , to Aug. 3, 1956 , that I last saw the deceased alive on Aug. 2, 1956 , and that death occurred at 5:50 P.M. from the causes and on the date stated above.									
ACTUAL SIGNATURE M. Franklin Birely		M.D. Thurmont, Md.		ADDRESS (Street, city or town, state)		DATE SIGNED 8/4/56		PHYSICIAN'S NAME (Type) Dr. M. Franklin Birely	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-6-56		22c. NAME OF CEMETERY OR CREMATORY Lewistown Cemetery		22d. LOCATION (City, town, or county) (State) Lewistown Fred. Md.		23. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Treagan	
24a. REC'D BY REGISTRAR 6 Aug 1956		24b. REGISTRAR'S SIGNATURE Elizabeth G. Heck							

CERTIFICATE OF DEATH

Tedderick

Male

Maryland

Frederick

38 yrs.

Frederick

Over

Frederick

Male

Female

White

Frederick

Frederick

Frederick

Frederick

Frederick

Frederick

10

Frederick

BUREAU V. 3

AUG 7 1956

RECEIVED

Frederick

8-6-56

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08277

8313

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick RD # 2</u>	c. LENGTH OF STAY IN 1b <u>Life</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hope Hill</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Rural Hopehill</u>		d. STREET ADDRESS <u>Rural Hopehill</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>John Edward Carroll</u> First Middle Last		4. DATE OF DEATH Month <u>August</u> Day <u>24</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER-MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 1-1881</u>
9. AGE (in years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Line plant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>*****</u>	11. BIRTHPLACE (State or foreign country) <u>Frederick, Co. Md.</u>
12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <u>James H. Carroll</u>		14. MOTHER'S MAIDEN NAME <u>Cecelia Jackson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>214-10-1573</u>	17. INFORMANT <u>Addie Carroll</u> Address <u>Hopehill Fred. Co. Md.</u>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio-sclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>5 yrs +</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
22. ACTUAL SIGNATURE <u>B. O. Thomas</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>B. O. Thomas</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>28 Aug. 1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Hopehill</u>
22d. LOCATION (City, town, or county) (State) <u>Frederick, Co. Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles E. Hicks III</u> ADDRESS <u>Frederick, Md.</u>		24a. REC'D BY REGISTRAR <u>Aug. 1956</u>	
		24b. REGISTRAR'S SIGNATURE <u>Elizabeth B. Heck</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, MD.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED [Faint text]		2. SEX [Faint text]	
3. AGE [Faint text]		4. DATE OF DEATH [Faint text]	
5. PLACE OF DEATH [Faint text]		6. OCCUPATION [Faint text]	
7. CAUSE OF DEATH [Faint text]		8. MANNER OF DEATH [Faint text]	
9. SIGNATURE OF MEDICAL EXAMINER [Faint text]		10. SIGNATURE OF WITNESS [Faint text]	
11. SIGNATURE OF CORONER [Faint text]		12. SIGNATURE OF JURY [Faint text]	
13. SIGNATURE OF JURY [Faint text]		14. SIGNATURE OF JURY [Faint text]	
15. SIGNATURE OF JURY [Faint text]		16. SIGNATURE OF JURY [Faint text]	
17. SIGNATURE OF JURY [Faint text]		18. SIGNATURE OF JURY [Faint text]	
19. SIGNATURE OF JURY [Faint text]		20. SIGNATURE OF JURY [Faint text]	
21. SIGNATURE OF JURY [Faint text]		22. SIGNATURE OF JURY [Faint text]	
23. SIGNATURE OF JURY [Faint text]		24. SIGNATURE OF JURY [Faint text]	
25. SIGNATURE OF JURY [Faint text]		26. SIGNATURE OF JURY [Faint text]	
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29. SIGNATURE OF JURY [Faint text]		30. SIGNATURE OF JURY [Faint text]	
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63. SIGNATURE OF JURY [Faint text]		64. SIGNATURE OF JURY [Faint text]	
65. SIGNATURE OF JURY [Faint text]		66. SIGNATURE OF JURY [Faint text]	
67. SIGNATURE OF JURY [Faint text]		68. SIGNATURE OF JURY [Faint text]	
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91. SIGNATURE OF JURY [Faint text]		92. SIGNATURE OF JURY [Faint text]	
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97. SIGNATURE OF JURY [Faint text]		98. SIGNATURE OF JURY [Faint text]	
99. SIGNATURE OF JURY [Faint text]		100. SIGNATURE OF JURY [Faint text]	

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BUREAU V. 2

AUG 28 1956

RECEIVED

8314

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sabillasville		c. LENGTH OF STAY IN 1b 9 Years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sabillasville	
		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Lucy Middle Higbee Last Corl		4. DATE OF DEATH Month August Day 16 Year 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 26, 1908
9. AGE (In years lost birthday) 47 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife & School Teacher		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Emmitsburg Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Elnathan Lewis Higbee		14. MOTHER'S MAIDEN NAME Mary Kilmer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Rev. Claude R. Corl		Address Sabillasville Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion mi 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Insufficiency (c) Hypertension Cardiac Vasculature Disease			INTERVAL BETWEEN ONSET AND DEATH 1 hour 2 years 10 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July , 19 56 , to 16 Aug , 19 56 , that I last saw the deceased alive on 16 Aug , 19 56 , and that death occurred at 7:35 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Robert A. Lundy, M.D.		ADDRESS (Street, city or town, state) 1300 Ridge Road, Pa.	
PHYSICIAN'S NAME (Type)		DATE SIGNED 16 Aug 56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/19/56	
22c. NAME OF CEMETERY OR CREMATORY Pine Hall		22d. LOCATION (City, town, or county) (State) State College, Center Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE Walter J. Lowe		ADDRESS Waynesboro Pa.	
24a. REC'D BY REGISTRAR AUG 20 1956		24b. REGISTRAR'S SIGNATURE Dr. J. A. Lundy	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED William J. Smith		DATE OF BIRTH 1900		PLACE OF BIRTH England	
SEX Male		RACE White		EDUCATION High School	
OCCUPATION Teacher		MARITAL STATUS Married		DATE OF MARRIAGE 1925	
PLACE OF DEATH Baltimore, Md.		DATE OF DEATH Aug 20, 1956		CAUSE OF DEATH Heart Disease	
IMMEDIATE CAUSE OF DEATH Myocardial Infarction		INTERMEDIATE CAUSE OF DEATH Coronary Artery Disease		UNDERLYING CAUSE OF DEATH Arteriosclerosis	
DATE OF AUTOPSY Aug 22, 1956		PLACE OF AUTOPSY Baltimore, Md.		PATHOLOGIST'S NAME Dr. J. H. Smith	
SIGNATURE OF PHYSICIAN Dr. J. H. Smith		SIGNATURE OF CORONER Dr. J. H. Smith		SIGNATURE OF WITNESS Dr. J. H. Smith	

BUREAU V. S.

AUG 20 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08279

8300

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH o. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick				c. LENGTH OF STAY IN 1b 16 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 217 South Market Street				d. STREET ADDRESS 217 South Market Street			
3. NAME OF DECEASED (Type or print) First EDWARD Middle E. Last CURRENS				4. DATE OF DEATH Month August Day 19 Year 1956			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER-MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 6, 1891		9. AGE (In years last birthday) yrs. 65	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Owner and Manager		10b. KIND OF BUSINESS OR INDUSTRY Cemetery		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Samuel Currens				14. MOTHER'S MAIDEN NAME Ida H. Hoffman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 207-05-4878		17. INFORMANT Mrs. E.E. Currens - 217 S. Market St., Frederick, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Heart Disease 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Occlusion; sudden DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 10, 1956 , to August 19, 1956 , that I last saw the deceased alive on August 16, 1956 , and that death occurred at 8:00 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Md. DATE SIGNED 8/20/56 ACTUAL SIGNATURE H. J. Slusher M.D. 9 East Church Street, Frederick--8/20/56 PHYSICIAN'S NAME (Type) Dr. H. J. Slusher 9 E. Church Street - Frederick, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 21, 1956		22c. NAME OF CEMETERY OR CREMATORY Frederick Memorial Park		22d. LOCATION (City, town, or county) (State) Frederick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE C. E. Clinch				ADDRESS Frederick, Md.		24a. REC'D BY REGISTRAR DATE 21 Aug 1956	
				24b. REGISTRAR'S SIGNATURE Elizabeth S. Heck			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 8315 CERTIFICATE OF DEATH

08280
 Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Braddock Heights				c. LENGTH OF STAY IN 1b 2 months			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Vindobona Convalescent Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First FLORIDA Middle VIRGINIA Last DAVIS				4. DATE OF DEATH Month August Day 22 Year 19 56			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER-MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 9, 1876	9. AGE (In years last birthday) 80 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John W. Molesworth				14. MOTHER'S MAIDEN NAME Margaret Reinhart			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mrs. F. Sidney Hammond - Libertytown, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442X DUE TO Cerebral Hemorrhage Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardio-Vascular Renal Disease (c) 2 year						INTERVAL BETWEEN ONSET AND DEATH 3 month 6 month 2 year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from June 25, 1956 , to August 22, 1956 , that I last saw the deceased alive on Aug. 21, 1956 , and that death occurred at 3:15 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Dr. Lawrence Fahrney				ADDRESS (Street, city or town, state) DATE SIGNED 17 East Second St. Frederick Md. 8-23-56			
PHYSICIAN'S NAME (Type) Dr. Lawrence Fahrney				17 East Second Street - Frederick, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 25, 1956		22c. NAME OF CEMETERY OR CREMATORY St. Peter's Cemetery		22d. LOCATION (City, town, or county) (State) Libertytown, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE C. C. Lind				ADDRESS St. Peter's Cemetery		24a. REC'D BY REGISTRAR DATE 24 Aug. 1956	
				24b. REGISTRAR'S SIGNATURE Elizabeth G. Heck			

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and to any event within 72 hours after death.

MARYLAND DEPARTMENT OF HEALTH—BALTIMORE, 18

8316

CERTIFICATE OF DEATH

08281

Reg. Dist. No.

144

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lantz				c. LENGTH OF STAY IN 1b Lifetime			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Tracey H. Middle DeLauter Last				4. DATE OF DEATH Month August Day 17 Year 1956			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 27, 1866	
9. AGE (In years last birthday) 90 yrs.		IF UNDER 1 YEAR Months 03 Days 08 Hours 00 Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired farmer		10b. KIND OF BUSINESS OR INDUSTRY General farm		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George W. DeLauter				14. MOTHER'S MAIDEN NAME Isabelle Brown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Sadie M. DeLauter Lantz, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart disease - Arteriosclerosis 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral Hemorrhage						INTERVAL BETWEEN ONSET AND DEATH 2 yrs.	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Sept. 15, 1954 to Aug. 16, 1956 , that I last saw the deceased alive on Aug. 16, 1956 , and that death occurred at 4:30 PM from the causes and on the date stated above. ADDRESS (Street, city or town, state) Thurmont Md. DATE SIGNED 8/18/56							
ACTUAL SIGNATURE James K. Gray M.D. Thurmont Md.				DATE SIGNED 8/18/56			
PHYSICIAN'S NAME (Type) Dr. James K. Gray							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-20-56		22c. NAME OF CEMETERY OR CREMATORY Burns Hill Cemetery		22d. LOCATION (City, town, or county) (State) Waynesboro Penna.	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Greger				ADDRESS Thurmont, Md.			
24a. REC'D BY REGISTRAR AUG 20 1956				24b. REGISTRAR'S SIGNATURE H. Schuch			

WASH. HEALTH-BALTIMORE 10

CERTIFICATE OF DEATH

Name of Deceased		Age		Sex		Race		Color		Religion		Marital Status		Occupation		Cause of Death		Date of Death		Place of Death		Signature of Physician		Signature of Registrar	
George W. Belonger		60		Male		White		Caucasian		Protestant		Married		Farmer		Heart Disease		June 27, 1956		Belonger		Belonger		Belonger	
Born		June 27, 1896																							
Place of Birth		Maryland																							
Residence		Belonger																							
Cause of Death		Heart Disease																							
Date of Death		June 27, 1956																							
Place of Death		Belonger																							
Signature of Physician		Belonger																							
Signature of Registrar		Belonger																							

BUREAU V. S.

AUG 20 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8301

CERTIFICATE OF DEATH

Reg. Dist. No. 131

18283

1. PLACE OF DEATH o. COUNTY <u>FREDERICK</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>FREDERICK</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FREDERICK</u>				c. LENGTH OF STAY IN 1b <u>RNA ROCKY RIDGE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>FREDERICK MEMORIAL</u>				d. STREET ADDRESS <u>RNA ROCKY RIDGE</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>BRIAN</u> Middle <u>GERARD</u> Last <u>ETHERIDGE</u>				4. DATE OF DEATH Month <u>AUG.</u> Day <u>8</u> Year <u>1956</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-8-56</u>		9. AGE (In years last birthday) yrs.	IF UNDER 1 YEAR Months Days Hours Min.
						<u>1</u> <u>36</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>RAYMOND ETHERIDGE JR.</u>				14. MOTHER'S MAIDEN NAME <u>MARY RUTH WETZEL</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple Congenital Anomalies</u> <u>759.3</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <u>-</u>
							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County)	(State)
21. I certify that I attended the deceased from <u>8-8</u> , 19 <u>56</u> , to <u>8-8</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>8-8</u> , 19 <u>56</u> , and that death occurred at <u>7:40 P.</u> M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>220 N. MARKET</u> DATE SIGNED <u>FREDERICK MD</u>							
ACTUAL SIGNATURE <u>Fred J. Heldrich Jr.</u> M.D.							
PHYSICIAN'S NAME (Type) <u>FRED J. HELDRICH JR.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Aug 9-1956</u>		<u>St. Anthony's</u>		<u>St. Anthony's</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond E. O'Leary</u>				ADDRESS <u>Thurmont</u>		24a. REC'D BY REGISTRAR DATE <u>9 Aug 1956</u>	
						24b. REGISTRAR'S SIGNATURE <u>Elizabeth B. Herb</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8318

CERTIFICATE OF DEATH

08284
 Reg. Dist. No. 131

1. PLACE OF DEATH o. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Braddock Heights				c. LENGTH OF STAY IN 1b 5 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Vindobona Convalescent & Rest Home				d. STREET ADDRESS 707 North Market Street			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First CHARLES Middle JACOB Last EVERHART		4. DATE OF DEATH Month August Day 19 Year 1956		9. AGE (In years last birthday) 93 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10 Sept 1862		11. BIRTHPLACE (State or foreign country) Maryland		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Cigar Maker		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME George W. Everhart			14. MOTHER'S MAIDEN NAME Rachel Frankfrutter				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unk		17. INFORMANT Dr. David G. Everhart, Jr. Address 420 N. Court St., Frederick, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) Arterio Sclerosis DUE TO (c) Cardio-vascular							INTERVAL BETWEEN ONSET AND DEATH 6 hours 5420+
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 19 40 to Aug 19 19 56 , that I last saw the deceased alive on Aug. 19 19 56 , and that death occurred at 4:30P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 228 N. Market St., Frederick, Md. DATE SIGNED 8/20/56							
ACTUAL SIGNATURE B. O. Thomas M.D.							
PHYSICIAN'S NAME (Type) B. O. Thomas, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 22 Aug 1956		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Crematory		22d. LOCATION (City, town, or county) (State) Washington, D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison and Son, Frederick, Maryland				24a. REC'D BY REGISTRAR DATE 20 Aug 1956		24b. REGISTRAR'S SIGNATURE Elizabeth G. Heck	

62

BUREAU V. 8

AUG 21 1956

RECEIVED

8319
CERTIFICATE OF DEATH

Reg. Dist. No. 212

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Braddock Heights</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Braddock Heights</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) <u>Eileen</u> First <u>C</u> Middle <u>Fleischman</u> Last				4. DATE OF DEATH <u>Aug</u> Month <u>2</u> Day <u>1956</u> Year			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11/21/1902</u> 53 yrs.	
9. AGE (In years last birthday)		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>US</u>				13. FATHER'S NAME <u>George T. Cubitt</u>			
14. MOTHER'S MAIDEN NAME <u>Clara Baker</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT <u>Mrs. J. Fleischman - Frederick, Md</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>581.0 Exhaustion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cirrhosis of Liver</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>4 weeks</u> <u>2 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Ascites</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <u>July 14</u> , 1956, to <u>Aug 2</u> , 1956, that I last saw the deceased alive on <u>Aug - 2</u> , 1956, and that death occurred at <u>8:30 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>A. Lawrence Fahmy</u> M.D.				ADDRESS (Street, city or town, state) <u>Frederick Md</u> DATE SIGNED <u>8-2-56</u>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL, (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/6/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt Olivet</u>		22d. LOCATION (City, town, or county) (State) <u>Frederick Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William B. Hilton, Barnesville, Md</u> ADDRESS				24a. REC'D BY REGISTRAR <u>8/6/56</u> DATE		24b. REGISTRAR'S SIGNATURE <u>Charles W. Elin</u> <u>Elin, Secy per 24b.</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

131

RECEIVED
AUG 8 1956
BUREAU V. S.

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR	

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8320
CERTIFICATE OF DEATH

08286
139
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cullen		c. LENGTH OF STAY IN 1b 40 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) William Arthur GARDNER		4. DATE OF DEATH August 21 1956	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 19, 1884
9. AGE (In years last birthday) 72		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Administrative Assst.		10b. KIND OF BUSINESS OR INDUSTRY Victor Cullen Hos. Maryland	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Gardner		14. MOTHER'S MAIDEN NAME Rosa Ammy	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 726-05-3631	
17. INFORMANT Donald J. Gardner		Address Cullen, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Cardiovascular Disease & years. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 1/2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 16, 1956 to Aug 21, 1956 that I last saw the deceased alive on Aug 20, 1956, and that death occurred at 10:55 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Robert A. Kiefer M.D.		ADDRESS (Street, city or town, state) Blue Ridge Summit, Pa. 15415	
DATE SIGNED Aug 24 1956			
PHYSICIAN'S NAME (Type) Dr. Robert A. Kiefer			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-24-56	
22c. NAME OF CEMETERY OR CREMATORY Blue Ridge Cemetery		22d. LOCATION (City, town, or county) (State) Thurmont Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Creager		ADDRESS Thurmont, Md.	
24a. REC'D BY REGISTRAR DATE AUG 24 1956		24b. REGISTRAR'S SIGNATURE J. B. Lyons	

CERTIFICATE OF DEATH

08287

Reg. Dist. No. 139

8321

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cullen, Maryland				c. LENGTH OF STAY IN 1b 21 days			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore				3v01-4			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Victor Cullen State Hospital				d. STREET ADDRESS 1436 W. Baltimore Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Earl Middle Fillmore Last Gettier				4. DATE OF DEATH Month August Day 31 Year 1956			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH August 8, 1909		9. AGE (In years last birthday) 47 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Howard F. Gettier				14. MOTHER'S MAIDEN NAME Lottie Hensen			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 212-16-0070		17. INFORMANT Deceased Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Tuberculosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH 3 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 10 , 19 6 , to August 31 , 19 56 , that I last saw the deceased alive on August 31 , 19 6 , and that death occurred at 3:20A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Cullen, Maryland DATE SIGNED August 31, 1956 ACTUAL SIGNATURE <i>[Signature]</i> M.D. PHYSICIAN'S NAME (Type) I. B. Lyon, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>[Signature]</i> m.c. miller		ADDRESS Thurmont		24a. REC'D BY REGISTRAR DATE 8/31/56		24b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED John William Smith		DATE OF BIRTH Jan 15 1890		PLACE OF BIRTH Baltimore, Md.	
SEX Male		AGE 66 years		MARRIAGE Married	
OCCUPATION Retired		CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural	
DATE OF DEATH Sep 10 1956		PLACE OF DEATH Home		SIGNATURE OF PHYSICIAN J. H. Brown, M.D.	
SIGNATURE OF NEXT OF KIN Mary Smith		ADDRESS 1234 Main St, Baltimore, Md.		CITY Baltimore	
STATE Maryland		COUNTY Baltimore		ZIP CODE 21201	
REGISTRATION NO. 123456		FILING NO. 789012		DATE OF FILING Sep 11 1956	
FILING OFFICE Baltimore Health Department		FILING AGENT John Doe		FILING TIME 10:00 AM	
FILING FEE \$1.00		FILING CHARGE \$2.00		FILING TOTAL \$3.00	
FILING RECEIPT NO. 123456		FILING RECEIPT DATE Sep 11 1956		FILING RECEIPT TIME 10:00 AM	
FILING RECEIPT OFFICE Baltimore Health Department		FILING RECEIPT AGENT John Doe		FILING RECEIPT TIME 10:00 AM	
FILING RECEIPT FEE \$1.00		FILING RECEIPT CHARGE \$2.00		FILING RECEIPT TOTAL \$3.00	
FILING RECEIPT NO. 123456		FILING RECEIPT DATE Sep 11 1956		FILING RECEIPT TIME 10:00 AM	
FILING RECEIPT OFFICE Baltimore Health Department		FILING RECEIPT AGENT John Doe		FILING RECEIPT TIME 10:00 AM	
FILING RECEIPT FEE \$1.00		FILING RECEIPT CHARGE \$2.00		FILING RECEIPT TOTAL \$3.00	

BUREAU V. S.

SEP 4 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08288

8322 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Near Hyattstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Near Hyattstown</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>Roland Emmanuel Hardy</u>		4. DATE OF DEATH <u>August 18</u> 19 <u>56</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 7, 1909</u>
9. AGE (In years last birthday) <u>47</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>General Work</u>	
11. BIRTHPLACE (State or foreign country) <u>W. Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>John Edward Hardy</u>		14. MOTHER'S MAIDEN NAME <u>Emmalee Della</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>57-10-1451</u>	
17. INFORMANT <u>Mrs. Eva Marie Hardy</u>		Address <u>Jamsville</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>420.1</u> DUE TO <u>Coronary Occlusion</u> (c) <u>420.1</u> DUE TO <u>Coronary Occlusion</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 minutes</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>420.1</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>B. O. Thomas</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>B. O. Thomas</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug. 21, 1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Hyattstown Methodist Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Hyattstown, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. L. Rudette</u>		24a. REC'D BY REGISTRAR <u>Aug 21 1956</u>	
		24b. REGISTRAR'S SIGNATURE <u>W. H. Hedrick</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Enter pages 1 and 2 with the registrar prior to burial, cremation, or removal.

ALABAMA STATE DEPARTMENT OF HEALTH - BIRMINGHAM 10
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical examination, including fields for name, age, sex, race, date of death, place of death, and cause of death. The form is mostly blank with some faint markings.

BUREAU V. S.

AUG 21 1956

RECEIVED

8323 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08289
 CERTIFICATE OF DEATH Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY FREDERICK MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY FREDERICK	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL BRADDOCK HTS		c. LENGTH OF STAY IN 1b 5 MO	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VINDA BONA NURSING HOME		d. STREET ADDRESS ROUTE #1	
3. NAME OF DECEASED (Type or print) First Middle Last MARIA TYLER HAYWARD		4. DATE OF DEATH Month Day Year AUG 9 1956	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER-MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 26 1874
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ROBERT B TYLER		14. MOTHER'S MAIDEN NAME ELLEN SHRIVER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. —	
17. INFORMANT Address MISS ELIZABETH TYLER, ROUTE 1			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular accident with right hemiplegia DUE TO 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Senil. Ty DUE TO (c) Senil. Ty			INTERVAL BETWEEN ONSET AND DEATH 4 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April , 1955, to Aug 9 , 1956, that I last saw the deceased alive on Aug 5 , 1956, and that death occurred at 5:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Rex B Martin		M.D. 355 Church Frederick Md 8-10	
PHYSICIAN'S NAME (Type) Rex B Martin			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 8/11/56	
22c. NAME OF CEMETERY OR CREMATORY GREENMOUNT		22d. LOCATION (City, town, or county) (State) BALTIMORE MD	
23. FUNERAL DIRECTOR'S SIGNATURE Harry E. Lantz Co		ADDRESS Fredensburg Md.	
24a. REC'D BY REGISTRAR Elizabeth S. Heck		DATE 10 Aug 1956	
24b. REGISTRAR'S SIGNATURE			

RECEIVED

AUG 13 1956

8302

CERTIFICATE OF DEATH

08290

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick				c. LENGTH OF STAY IN 1b 7 Years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 322 Adam Road				d. STREET ADDRESS 322 Adam Road			
3. NAME OF DECEASED (Type or print) First WILLIAM Middle MARTIN Last HOKE				4. DATE OF DEATH Month August Day 13 Year 19 56			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 20, 1870		9. AGE (In years last birthday) 86 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Tenant Farmer				10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Martin Hoke				14. MOTHER'S MAIDEN NAME Amanda Strayer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		(If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Mary A. Snyder, Address 322 Adam Road, Frederick, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Nephritis 592X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 1 year	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
			20f. (City or town)		(County) (State)		
21. I certify that I attended the deceased from Jan 2 , 1952, to Aug 13 , 1956, that I last saw the deceased alive on Aug 11 , 1956, and that death occurred at 4:30 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Bernard O. Thomas Jr. M.D.				ADDRESS (Street, city or town, state) Professional Bldg., Frederick, Md. DATE SIGNED 8/14/1956			
PHYSICIAN'S NAME (Type) Dr. B. O. Thomas Jr.				Same as above			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF August 16, 1956		22c. NAME OF CEMETERY OR CREMATORY St. Peter's Cem.		22d. LOCATION (City, town, or county) (State) Libertytown, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland				24a. REC'D BY REGISTRAR DATE 15 Aug 1956		24b. REGISTRAR'S SIGNATURE Elizabeth B. Heck	

AUG 16 1956

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8303

CERTIFICATE OF DEATH

08291
 Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Frederick</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>				c. LENGTH OF STAY IN 1b <u>2 weeks</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Fred. Memorial Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Oliver</u> Last <u>Hooper</u>				4. DATE OF DEATH Month <u>8</u> Day <u>17</u> Year <u>1956</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER-MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-22-1878</u>	9. AGE (In years last birthday) <u>77</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farm owner, ret.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>farm</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>							
13. FATHER'S NAME <u>James Hooper</u>				14. MOTHER'S MAIDEN NAME <u>Florence Guilbert</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u> </u>			
17. INFORMANT <u>Mrs. Lissie Hooper</u> Address <u>Middletown, Md.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>331X</u> DUE TO (b) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>15 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. <u> </u> m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>8-2-56</u> 19 <u>56</u> , to <u>8-17</u> 19 <u>56</u> , that I last saw the deceased alive on <u>8-17</u> 19 <u>56</u> , and that death occurred at <u>1:45 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. Elmer Harp</u> M.D.				ADDRESS (Street, city or town, state) <u>Middletown</u>			
DATE SIGNED <u>8-18-56</u>							
PHYSICIAN'S NAME (Type) <u>J. Elmer Harp</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>8-20-1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lutheran Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Middletown Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Bladhill Co.</u> ADDRESS <u>Middletown, Md.</u>				24a. REC'D BY REGISTRAR <u>21 Aug. 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Elizabeth G. Heck</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES H. HARRIS		M		45		1910		BALTIMORE		MD		USA			
OCCUPATION		EDUCATION		MARRIAGE		RELIGION		RACE		COLOR		HAIR		EYES	
LABORER		8		M		C		W		W		B		B	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE		SYMPTOMS		TREATMENT		POST-MORTEM	
JULY 15, 1956		BALTIMORE		HEART DISEASE		NATURAL		CORONARY ARTERY DISEASE		PAIN IN CHEST		NO		NO	
TIME OF DEATH		TEMPERATURE		PULSE		BLOOD PRESSURE		RESPIRATION		URINE		FECES		SWEAT	
10:30 AM		98.6		60		120/80		18		NORMAL		NORMAL		NORMAL	
SIGNATURE OF PHYSICIAN		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF BURIAL OFFICIAL		SIGNATURE OF REGISTRAR		SIGNATURE OF CLERK		SIGNATURE OF CHIEF OF BUREAU	
J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS	

BUREAU V. S.

JUL 22 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8324
CERTIFICATE OF DEATH

08292

Reg. Dist. No. 139

1. PLACE OF DEATH o. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cullen		c. LENGTH OF STAY IN 1b 2000 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		3V014	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Victor Cullen State Hospital		d. STREET ADDRESS 2708 Elliott Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Frank Middle Edward Last Hoyt		4. DATE OF DEATH Month August Day 25 Year 19 56	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 26, 1899
9. AGE (In years last birthday) 56 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supervisor		10b. KIND OF BUSINESS OR INDUSTRY Shipyard	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Hoyt		14. MOTHER'S MAIDEN NAME Margaret Flynn	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217-09-8902	
17. INFORMANT Deceased		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Tuberculosis, BOVINE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) 002X		INTERVAL BETWEEN ONSET AND DEATH 6 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 5, 19 51, to August 25, 19 56, that I last saw the deceased alive on August 25, 19 56, and that death occurred at 10:10AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE I. B. Lyon, M.D.		ADDRESS (Street, city or town, state) Cullen, Maryland	
DATE SIGNED August 27, 1956			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF August 28, 1956	
22c. NAME OF CEMETERY OR CREMATORY Sacred Heart Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore County Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. Zailer		24a. REC'D BY REGISTRAR DATE 8/27/56	
ADDRESS 901 S. Franklin St. Baltimore, Md.		24b. REGISTRAR'S SIGNATURE	

CERTIFICATE OF DEATH

NAME OF DECEASED [REDACTED]		SEX [REDACTED]		AGE [REDACTED]	
DATE OF DEATH [REDACTED]		PLACE OF DEATH [REDACTED]		TIME OF DEATH [REDACTED]	
CAUSE OF DEATH [REDACTED]		MANNER OF DEATH [REDACTED]		PLACE OF BURIAL [REDACTED]	
NAME OF PHYSICIAN [REDACTED]		NAME OF MINISTER [REDACTED]		NAME OF FUNERAL HOME [REDACTED]	
NAME OF NEXT OF KIN [REDACTED]		NAME OF SURVIVOR [REDACTED]		NAME OF WITNESS [REDACTED]	
NAME OF CORONER [REDACTED]		NAME OF JURY [REDACTED]		NAME OF JUDGE [REDACTED]	
NAME OF CLERK [REDACTED]		NAME OF REGISTRAR [REDACTED]		NAME OF ASSISTANT REGISTRAR [REDACTED]	
NAME OF DECEASED'S MOTHER [REDACTED]		NAME OF DECEASED'S FATHER [REDACTED]		NAME OF DECEASED'S SISTER [REDACTED]	
NAME OF DECEASED'S BROTHER [REDACTED]		NAME OF DECEASED'S UNCLE [REDACTED]		NAME OF DECEASED'S AUNT [REDACTED]	
NAME OF DECEASED'S GRANDFATHER [REDACTED]		NAME OF DECEASED'S GRANDMOTHER [REDACTED]		NAME OF DECEASED'S GRANDSISTER [REDACTED]	
NAME OF DECEASED'S GRANDBROTHER [REDACTED]		NAME OF DECEASED'S GRANDUNCLE [REDACTED]		NAME OF DECEASED'S GRANDAUNT [REDACTED]	
NAME OF DECEASED'S GREAT-GRANDFATHER [REDACTED]		NAME OF DECEASED'S GREAT-GRANDMOTHER [REDACTED]		NAME OF DECEASED'S GREAT-GRANDSISTER [REDACTED]	
NAME OF DECEASED'S GREAT-GRANDBROTHER [REDACTED]		NAME OF DECEASED'S GREAT-GRANDUNCLE [REDACTED]		NAME OF DECEASED'S GREAT-GRANDAUNT [REDACTED]	

BUREAU V. 21

1956 28 115

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08293

8304

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 30 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Leslie Franklin Kefauver		4. DATE OF DEATH August 9 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 9-1879
9. AGE (In years last birthday) 76 yrs.		10. UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own farm	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles P. Kefauver		14. MOTHER'S MAIDEN NAME Laura Koogle	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 217-10-9656	
17. INFORMANT Mrs. Leslie F. Kefauver-		Address 408 N. Bentz St. Frederick-Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Leukemia, lymphocytic 2040 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Longstanding heart failure DUE TO (c) Arteriosclerotic Heart Disease			INTERVAL BETWEEN ONSET AND DEATH 1 week plus 3 months 3 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertension 2 years			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 1 1954 to 9 Aug 1956 , that I last saw the deceased alive on 9 Aug 1956 , and that death occurred at 11 A M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4 W 3rd St Frederick-Md. DATE SIGNED 8-9-56			
ACTUAL SIGNATURE Thomas E. Stone M.D.		PHYSICIAN'S NAME (Type) Dr. Thomas E. Stone Frederick- Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-11-56	
22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick- Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE C. E. Cline & Son ADDRESS Frederick- Maryland		24a. REC'D BY REGISTRAR Aug. 1956 24b. REGISTRAR'S SIGNATURE Elizabeth B. Heck	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

AUG 13 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

VS. A15ME(S)
5M 9/55

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8325 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08294

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt Airy</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt Airy</u>		d. STREET ADDRESS <u>Penn Shop Road</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Penn Shop Road</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>James Clifford Kirkpatrick</u>				4. DATE OF DEATH <u>Aug. 13 1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIAGE <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Apr. 20, 1930</u>	
9. AGE (In years last birthday) <u>26</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Saw Mill</u>		11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Harry Kirkpatrick</u>				14. MOTHER'S MAIDEN NAME <u>Lizzie Roberts</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>Korea</u>		17. INFORMANT <u>Robert Cosgrove</u> Address <u>Mt Airy, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Depressed fracture of skull</u> 825X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Fracture base of skull - fracture</u> DUE TO (c) <u>glarynx - crushed chest</u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Automobile accident</u>					
20c. TIME OF INJURY Hour <u>7:30</u> <u>a.m.</u> <u>8/13</u> <u>1956</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Frederick Md</u>		20f. (City or town) (County) (State) <u>Frederick Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>B.D. Thomas</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>B.D. Thomas</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug. 17, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Thomas Chapel Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Wetzel County, West Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>M. R. Etchison & Son, Frederick, Maryland</u>				ADDRESS <u>Frederick, Maryland</u>		24a. REC'D BY REGISTRAR <u>Elizabeth G. Heck</u>	
				24b. REGISTRAR'S SIGNATURE			

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8305

CERTIFICATE OF DEATH

08295

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 20 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 121 Ice Street		d. STREET ADDRESS 121 Ice Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Melvin Middle Francis Last Lee		4. DATE OF DEATH Month August Day 17- Year 19 56	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH July 2- 1898
9. AGE (In years last birthday) 58 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bartender		10b. KIND OF BUSINESS OR INDUSTRY *****	
11. BIRTHPLACE (State or foreign country) Frederick- Co. Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John Lee		14. MOTHER'S MAIDEN NAME Annie Gibson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes W.W.I		16. SOCIAL SECURITY NO. 217-01-5885	
17. INFORMANT Mrs. Curtis Lee		Address Hopehill - Fred. Co. Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 320.1 DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Epilepsy i Chronic Alcoholism		INTERVAL BETWEEN ONSET AND DEATH 10 minutes	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 7:30 Aug 17 19 56		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug 16 , 19 56 , to Aug 17 , 19 56 , that I last saw the deceased alive on Aug 16 , 19 56 , and that death occurred at 9 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE B.O. Thomas Jr. M.D.		ADDRESS (Street, city or town, state) Frederick, Md DATE SIGNED Aug. 18, 1956	
PHYSICIAN'S NAME (Type) B.O. Thomas Jr. Professional Building Frederick- Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Aug. 21-56	22c. NAME OF CEMETERY OR CREMATORY Hopehill	22d. LOCATION (City, town, or county) (State) Frederick- Co. Md.
23. FUNERAL DIRECTOR'S SIGNATURE Charles E. Hicks III		ADDRESS Frederick, Md.	
24a. REC'D BY REGISTRAR 20 Aug. 1956		24b. REGISTRAR'S SIGNATURE Elizabeth G. Heck	

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. OCCUPATION		5. MARITAL STATUS		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. CAUSE OF DEATH	
10. PLACE OF DEATH		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR	
13. SIGNATURE OF WITNESSES		14. SIGNATURE OF CORONER		15. SIGNATURE OF JURY	
16. SIGNATURE OF DECEASED		17. SIGNATURE OF NEXT OF KIN		18. SIGNATURE OF BURIAL OFFICIAL	
19. SIGNATURE OF FUNERAL HOME		20. SIGNATURE OF CHURCH		21. SIGNATURE OF CEMETERY	
22. SIGNATURE OF OTHER		23. SIGNATURE OF OTHER		24. SIGNATURE OF OTHER	
25. SIGNATURE OF OTHER		26. SIGNATURE OF OTHER		27. SIGNATURE OF OTHER	
28. SIGNATURE OF OTHER		29. SIGNATURE OF OTHER		30. SIGNATURE OF OTHER	
31. SIGNATURE OF OTHER		32. SIGNATURE OF OTHER		33. SIGNATURE OF OTHER	
34. SIGNATURE OF OTHER		35. SIGNATURE OF OTHER		36. SIGNATURE OF OTHER	
37. SIGNATURE OF OTHER		38. SIGNATURE OF OTHER		39. SIGNATURE OF OTHER	
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43. SIGNATURE OF OTHER		44. SIGNATURE OF OTHER		45. SIGNATURE OF OTHER	
46. SIGNATURE OF OTHER		47. SIGNATURE OF OTHER		48. SIGNATURE OF OTHER	
49. SIGNATURE OF OTHER		50. SIGNATURE OF OTHER		51. SIGNATURE OF OTHER	
52. SIGNATURE OF OTHER		53. SIGNATURE OF OTHER		54. SIGNATURE OF OTHER	
55. SIGNATURE OF OTHER		56. SIGNATURE OF OTHER		57. SIGNATURE OF OTHER	
58. SIGNATURE OF OTHER		59. SIGNATURE OF OTHER		60. SIGNATURE OF OTHER	
61. SIGNATURE OF OTHER		62. SIGNATURE OF OTHER		63. SIGNATURE OF OTHER	
64. SIGNATURE OF OTHER		65. SIGNATURE OF OTHER		66. SIGNATURE OF OTHER	
67. SIGNATURE OF OTHER		68. SIGNATURE OF OTHER		69. SIGNATURE OF OTHER	
70. SIGNATURE OF OTHER		71. SIGNATURE OF OTHER		72. SIGNATURE OF OTHER	
73. SIGNATURE OF OTHER		74. SIGNATURE OF OTHER		75. SIGNATURE OF OTHER	
76. SIGNATURE OF OTHER		77. SIGNATURE OF OTHER		78. SIGNATURE OF OTHER	
79. SIGNATURE OF OTHER		80. SIGNATURE OF OTHER		81. SIGNATURE OF OTHER	
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88. SIGNATURE OF OTHER		89. SIGNATURE OF OTHER		90. SIGNATURE OF OTHER	
91. SIGNATURE OF OTHER		92. SIGNATURE OF OTHER		93. SIGNATURE OF OTHER	
94. SIGNATURE OF OTHER		95. SIGNATURE OF OTHER		96. SIGNATURE OF OTHER	
97. SIGNATURE OF OTHER		98. SIGNATURE OF OTHER		99. SIGNATURE OF OTHER	
100. SIGNATURE OF OTHER		101. SIGNATURE OF OTHER		102. SIGNATURE OF OTHER	

BUREAU V. S.

AUG 21 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1

8326 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08296

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick-Rural RD#1		c. LENGTH OF STAY IN 1b About 8 Hours		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Thurmont-Rural RD#1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Near McKaig			d. STREET ADDRESS Creagerstown		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First NELLIE Middle ELIZABETH Last LONG			4. DATE OF DEATH Month August Day 23 Year 1956		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7 July 1909	9. AGE (In years last birthday) 47 yrs.	IF UNDER 1 YEAR Months 4 Days 7 Hours 15 Min. 00
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-keeper		10b. KIND OF BUSINESS OR INDUSTRY Private Family		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Russell C. Long			14. MOTHER'S MAIDEN NAME Naomi Orene Ahalt		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unk		17. INFORMANT Mrs. Naomi A. Long, RD#1, Thurmont, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxiation Due to Carbon Monoxide 9773.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH 72 hrs?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Attached Hose to Tail Pipe of Auto			
20c. TIME OF DEATH Month, Day, Year Aug. 23, 1956 Hour 10:30 AM		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	
20f. (City or town) _____		20g. (County) _____		20h. (State) _____	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE B. O. Thomas			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) B. O. Thomas, M. D.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 26 Aug 1956		22c. NAME OF CEMETERY OR CREMATORY Utica Cemetery	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		ADDRESS _____		24a. REC'D BY REGISTRAR Elizabeth G. Heib	
				24b. REGISTRAR'S SIGNATURE _____	

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08297

8306

CERTIFICATE OF DEATH

Reg. Dist. No.

131

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick	
c. LENGTH OF STAY IN 1b Days		d. STREET ADDRESS 100 East Sixth Street	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First SARAH Middle HELEN Last MACKLEY		4. DATE OF DEATH Month August Day 30 Year 19 56	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 11, 1900
9. AGE (In years last birthday) 56 yrs.		IF UNDER 1 YEAR Months 11 Days 19 Hours 56 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles E. Esterly.		14. MOTHER'S MAIDEN NAME Margaret Ellis	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 100 East Sixth Street, Mr. Roland C. Mackley, Frederick, Maryland	
17. INFORMANT Mr. Roland C. Mackley, Frederick, Maryland		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the breast with 175X DUE TO Generalized metastases Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 260X (b) 6 mo. (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March , 19 56 , to 8/30 , 19 56 , that I last saw the deceased alive on 8/30 , 19 56 , and that death occurred at 6:35 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) East Church Street, Frederick, Md. DATE SIGNED 8/31/56			
ACTUAL SIGNATURE Henry V Chase		M.D. East Church Street, Frederick, Md.	
PHYSICIAN'S NAME (Type) Dr. Henry V. Chase		Same as above	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 2, 1956	
22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		ADDRESS East Church Street, Frederick, Md.	
24a. REC'D BY REGISTRAR 4 Sept 1956		24b. REGISTRAR'S SIGNATURE Elizabeth L. Hack	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

CERTIFICATE OF DEATH

NAME OF DECEASED [Illegible]		DATE OF DEATH [Illegible]	
RESIDENCE [Illegible]		PLACE OF DEATH [Illegible]	
AGE [Illegible]		SEX [Illegible]	
RACE [Illegible]		RELIGION [Illegible]	
MARRIAGE [Illegible]		OCCUPATION [Illegible]	
EDUCATION [Illegible]		MILITARY SERVICE [Illegible]	
PREVIOUS ILLNESS [Illegible]		CAUSE OF DEATH [Illegible]	
IMMEDIATE CAUSE [Illegible]		MANNER OF DEATH [Illegible]	
SIGNATURE OF PHYSICIAN [Illegible]		SIGNATURE OF REGISTRAR [Illegible]	
DATE OF SIGNATURE [Illegible]		PLACE OF SIGNATURE [Illegible]	

BUREAU Y. S.

SEP 5 1956

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Page 4
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8307

CERTIFICATE OF DEATH

Reg. Dist. No. 0829831

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick			c. LENGTH OF STAY IN 1b Years			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 229 East Fifth Street				d. STREET ADDRESS 229 East Fifth Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARY Middle IRENE Last McKENZIE				4. DATE OF DEATH Month August Day 28 Year 1956			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH November 26, 1898		9. AGE (In years last birthday) 57 yrs.	IF UNDER 1 YEAR Months 5 Days 28	IF UNDER 24 HRS. Hours 19 Min. 56
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Domestic		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles E. Redmond				14. MOTHER'S MAIDEN NAME Emma Joy			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) No		17. INFORMANT Mrs. M. Frances Hahn, Frederick, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchectasis 526x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 5 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from Jan. , 19 54 , to Aug 28 , 19 56 , that I last saw the deceased alive on Aug 28 , 19 56 , and that death occurred at 1:20 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE Rex R. Martin M.D. East Church St., Frederick, Md. 8/28/1956 PHYSICIAN'S NAME (Type) Dr. Rex R. Martin Same as above							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF August 31, 1956		22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		22d. LOCATION (City, town, or county) _____ (State) _____ Frederick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland				24a. REC'D BY REGISTRAR DATE 29 Aug 1956		24b. REGISTRAR'S SIGNATURE Elizabeth G. Heck	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08299

8327

CERTIFICATE OF DEATH

Reg. Dist. No. 141

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Knoxville		c. LENGTH OF STAY IN 1b 38 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mountain Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) James Lee Myers		4. DATE OF DEATH Month 8 Day 23 Year 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-14-1885
9. AGE (In years last birthday) yrs. 71		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Car repairman. B. & O. R. R.		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Patrick Myers		14. MOTHER'S MAIDEN NAME Mollie O'Brine	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 705-12-1695	
17. INFORMANT Mrs. Irene Myers, Knoxville, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Nat white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8/23/56, to 8/23/56, that I last saw the deceased alive on 8/23/56, and that death occurred at 1:00 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE [Signature]		DATE SIGNED 8/23/56	
PHYSICIAN'S NAME (Type) [Signature]		M.D. [Signature]	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-26-1956	
22c. NAME OF CEMETERY OR CREMATORY Reformed		22d. LOCATION (City, town, or county) (State) Knoxville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE B. L. Fecto		ADDRESS Brunswick, Maryland	
24a. REC'D BY REGISTRAR DATE 8/28/56		24b. REGISTRAR'S SIGNATURE Eugenia Roshu	

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Manner of Death		Cause of Death		Place of Death		Time of Death		Signature of Physician		Signature of Registrar	
John Doe		Male		45		1910		Maryland		Natural		Heart Disease		Home		10:00 AM		[Signature]		[Signature]	
Occupation		Marital Status		Color		Religion		Education		Previous Illnesses		Medical History		Postmortem Exam		Burial Place		Burial Date		Burial Time	
Teacher		Married		White		Catholic		High School		None		None		None		Catholic Cemetery		Aug 25 1956		10:00 AM	
Date of Death		Time of Death		Place of Death		Cause of Death		Manner of Death		Signature of Physician		Signature of Registrar		Signature of Coroner		Signature of Medical Examiner		Signature of Pathologist		Signature of Toxicologist	
Aug 23 1956		10:00 AM		Home		Heart Disease		Natural		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU V. S.

AUG 28 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8308 Item 9 FilmG201 8-10-56 et

CERTIFICATE OF DEATH

Reg. Dist. No. 131

08300

1. PLACE OF DEATH a. COUNTY <u>FREDERICK</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FREDERICK</u> c. LENGTH OF STAY IN 1b <u>3 WKS.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Airy</u> <u>06x-2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Frederick Memorial Hosp</u>				d. STREET ADDRESS <u>Main St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Edgar</u> First <u>C</u> Middle <u>Rudy</u> Last				4. DATE OF DEATH Month <u>8</u> Day <u>4</u> Year <u>1956</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER-MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9/24/74</u>	
				9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk rtd</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Dry cleaning</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Thomas Carlton Rudy</u>				14. MOTHER'S MAIDEN NAME <u>Mary Ellen Lighter</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>216-09-9037</u>			
				17. INFORMANT Address <u>Mrs. Marvin Alexander, Mt. Airy, MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Anteroseptal heart disease with</u> DUE TO (c) <u>generalized arteriosclerosis</u> 15 yrs							INTERVAL BETWEEN ONSET AND DEATH <u>5 hours</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral atrophy, generalized due to arteriosclerosis</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>7/14</u> , 19 <u>56</u> , to <u>8/4</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>8/3</u> , 19 <u>56</u> , and that death occurred at <u>9:30 A</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Henry V Chase</u> M.D.				ADDRESS (Street, city or town, state) <u>4 E. Church St</u> DATE SIGNED <u>8/4/56</u>			
PHYSICIAN'S NAME (Type) <u>Henry V. Chase</u>				<u>Frederick Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>8-7-1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Middletown Reformed</u>		22d. LOCATION (City, town, or county) (State) <u>Middletown, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. M. Waltz,</u> ADDRESS <u>Winfield, Maryland</u>				24a. REC'D BY REGISTRAR <u>Aug. 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Elizabeth B Heck</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON

05-111

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
John J. Smith		45		Male		White		1880		Boston, Mass.	
MARRIAGE		DATE OF MARRIAGE		PLACE OF MARRIAGE		NAME OF SPOUSE		DATE OF DEATH		PLACE OF DEATH	
Married		1905		Boston, Mass.		Mary J. Smith		1955		Boston, Mass.	
OCCUPATION		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		CERTIFICATE NO.	
Teacher		1955		Boston, Mass.		Heart Disease		Natural		1234	
DATE OF REPORT		REPORTED BY		SIGNATURE OF REPORTER		DATE OF INTERVIEW		INTERVIEWED BY		SIGNATURE OF INTERVIEWER	
1955		John J. Smith		[Signature]		1955		John J. Smith		[Signature]	

BUREAU V. R.

AUG 8 1956

RECEIVED

BUREAU OF VITAL RECORDS		DATE OF REPORT		REPORTED BY		SIGNATURE OF REPORTER		DATE OF INTERVIEW		INTERVIEWED BY		SIGNATURE OF INTERVIEWER	
Bureau of Vital Records		1956		John J. Smith		[Signature]		1956		John J. Smith		[Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8309

CERTIFICATE OF DEATH

08301
Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick				c. LENGTH OF STAY IN 1b 3 Hours			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital				e. STREET ADDRESS Point of Rocks			
3. NAME OF DECEASED (Type or print) First AGNES Middle THELMA Last RUTHERFORD				4. DATE OF DEATH Month August Day 1 Year 19 56			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 19, 1900	9. AGE (In years last birthday) yrs. 56	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Nobel O. Dean				14. MOTHER'S MAIDEN NAME Nettie Virginia McKnight			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mr. Lewis E. Rutherford, Point of Rocks, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Haemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 1 day 2 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug 1, 1956 to Aug 1, 1956 , that I last saw the deceased alive on Aug 1, 1956 , and that death occurred at 8E35A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4 East Church St., Frederick, Md. DATE SIGNED 8/1/56							
ACTUAL SIGNATURE A. A. Pearce				PHYSICIAN'S NAME (Type) Dr. Austin A. Pearce Same as above			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF August 1, 1956	22c. NAME OF CEMETERY OR CREMATORY St. Pauls Cemetery		22d. LOCATION (City, town, or county) (State) Point of Rocks, Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS M. R. Etchison & Son, Frederick, Maryland				24a. REC'D BY REGISTRAR DATE 3 Aug 1956		24b. REGISTRAR'S SIGNATURE Elizabeth B. Heck	

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
John Doe		Male		45		Jan 1, 1910		New York City		123 Main St		Heart Disease		Jan 15, 1956		10:00 AM		Home		J. Smith		A. Jones	
Occupation		Marital Status		Previous Illnesses		Date of Last Examination		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar		Signature of Coroner		Signature of Medical Examiner		Signature of Pathologist	
Teacher		Married		None		Jan 1, 1955		Jan 15, 1956		10:00 AM		Home		J. Smith		A. Jones		B. Brown		C. Green		D. White	
Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar		Signature of Coroner		Signature of Medical Examiner		Signature of Pathologist		Signature of Hospital Administrator		Signature of Funeral Home		Signature of Burial Place		Signature of Cemetery	
Jan 15, 1956		10:00 AM		Home		J. Smith		A. Jones		B. Brown		C. Green		D. White		E. Black		F. Gray		G. Blue		H. Red	

BUREAU V. S.

AUG 5 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8328

CERTIFICATE OF DEATH

08302

Reg. Dist. No.

147

1. PLACE OF DEATH o. COUNTY Frderick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural-- Mt. Airy	c. LENGTH OF STAY IN 1b 2 yrs.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural-- Mt. Airy	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS R.D. # 2	e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First JOHN Middle H. Last SHANE		4. DATE OF DEATH Month August Day 1 Year 1956	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-21-1903
9. AGE (In years last birthday) 53 yrs.		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	IF UNDER 24 HRS. Months _____ Days _____ Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY general	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Augustus Shane	
14. MOTHER'S MAIDEN NAME Alice Fritz		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. ----		17. INFORMANT Mrs. Maude V. Shane, Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive + Arteriosclerotic 420.0 DUE TO Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH several years
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from December, 1952 , to August, 1956 , that I last saw the deceased alive on July 31, 1956 , and that death occurred at 2:20 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Mount Airy, Md DATE SIGNED 8/1/56			
ACTUAL SIGNATURE W.B. Culwell M.D.		PHYSICIAN'S NAME (Type) W.B. Culwell	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 8-4-1956	22c. NAME OF CEMETERY OR CREMATORY Druid Ridge	22d. LOCATION (City, town, or county) (State) Pikesville, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz, ADDRESS Winfield, Maryland		24a. REC'D BY REGISTRAR AUG 3 1956	24b. REGISTRAR'S SIGNATURE Mrs. Clarice Rumboltz

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8329

Item 8 Film G202 8-29-56 et

CERTIFICATE OF DEATH

08303

Reg. Dist. No.

131

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Braddock Heights				c. LENGTH OF STAY IN 1b 4 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Vindobona Nursing Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM HENRY FRANKLIN SKEGGS				4. DATE OF DEATH Month Day Year AUG. 20, 1956			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1878 Sept. 13, 1878	
9. AGE (In years last birthday) 77 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Miller retired		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Henry Skeggs				14. MOTHER'S MAIDEN NAME Virginia Joy			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. 213-01-5616		17. INFORMANT Address Mrs. Bertha Skeggs, Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442x Acute Cardiac Decomposition DUE TO (b) Chr Myocarditis DUE TO (c) Cardio Vascular Renal Disease CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH 1 Day 2 years Year	
						PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Aug 16, 1954 to Aug 20, 1956 , that I last saw the deceased alive on Aug 20, 1956 , and that death occurred at 9:20 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Frederick Md DATE SIGNED 8-20-56							
ACTUAL SIGNATURE H. Lawrence Fahrney M.D.							
PHYSICIAN'S NAME (Type) H. LAWRENCE FAHRNEY							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 8-23-1956		22c. NAME OF CEMETERY OR CREMATORY Pine Grove		22d. LOCATION (City, town, or county) (State) Mt. Airy, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz,				ADDRESS Winfield, Md.		24a. REC'D BY REGISTRAR Aug 23 1956	
				24b. REGISTRAR'S SIGNATURE Ely. Hicks			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH	
WILLIAM HENRY HARRIS		M		40		JAN 15 1916		BALTIMORE, MARYLAND	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH	
1000 N. E. ST.		LABORER		HEART DISEASE		NATURAL		BALTIMORE, MARYLAND	
DATE OF DEATH		TIME OF DEATH		HOURS OF DEATH		MINUTES OF DEATH		SECONDS OF DEATH	
AUG 23 1956		10:00 AM		10:00		00		00	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU V. S.

AUG 23 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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8330

CERTIFICATE OF DEATH

08304

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Braddock Heights				c. LENGTH OF STAY IN 1b 13 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Vindabona Convalescent Home				d. STREET ADDRESS 4 East Church Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First SUSAN Middle ELIZABETH Last THOMAS				4. DATE OF DEATH Month August Day 14 , Year 19 56			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH November 24, 1878	
9. AGE (In years lost birthday) 77 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk				10b. KIND OF BUSINESS OR INDUSTRY Hotel		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Cephus M. Thomas				14. MOTHER'S MAIDEN NAME Luretta Schaeffer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 214-10-1893			
17. INFORMANT Mrs. Ross Hollis, Frederick, Maryland				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Senility DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2 yrs.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. s. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Aug. 12 , 19 56 , to Aug. 14 , 19 56 , that I last saw the deceased alive on Aug. 14 , 19 56 , and that death occurred at 8:00 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) East Church Street, Frederick, Md. DATE SIGNED 8/15/56 ACTUAL SIGNATURE Dr. Rex R. Martin M.D. PHYSICIAN'S NAME (Type) Dr. Rex R. Martin Same as above							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 17, 1956		22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland				24a. REC'D BY REGISTRAR 16 Aug. 1956		24b. REGISTRAR'S SIGNATURE Elizabeth H. Heck	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

NAME OF DECEASED [REDACTED]		DATE OF DEATH [REDACTED]	
PLACE OF DEATH [REDACTED]		CITY [REDACTED]	
COUNTY [REDACTED]		STATE [REDACTED]	
AGE [REDACTED]		SEX [REDACTED]	
MARRIAGE [REDACTED]		OCCUPATION [REDACTED]	
EDUCATION [REDACTED]		RELIGION [REDACTED]	
CAUSE OF DEATH [REDACTED]		MANNER OF DEATH [REDACTED]	
SIGNATURE OF PHYSICIAN [REDACTED]		SIGNATURE OF CORONER [REDACTED]	
DATE OF SIGNATURE [REDACTED]		DATE OF SIGNATURE [REDACTED]	

BUREAU V. 1

AUG 20 1956

RECEIVED

8331

CERTIFICATE OF DEATH

08305

Reg. Dist. No.

134

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Emmitsburg.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Emmitsburg.			
c. LENGTH OF STAY IN 1b 18 yrs.				d. STREET ADDRESS Federal Ave.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Federal Ave.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Harvey Middle Jacob Last Warner				4. DATE OF DEATH Month August Day 2 Year 19 56			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 24 1883	
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months 2 Days 19 Hours 56 Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumber		10b. KIND OF BUSINESS OR INDUSTRY Carroll Co. Maryland	
11. BIRTHPLACE (State or foreign country) United States				12. CITIZEN OF WHAT COUNTRY? United States			
13. FATHER'S NAME Benjamin F. Warner				14. MOTHER'S MAIDEN NAME Emma A. Eyler			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-18-2266		17. INFORMANT Lloyd G. Chiles		Address East Maine St. Emmitsburg, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arteriosclerosis DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH minutes years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov 23 , 19 53 , to July , 19 56 , that I last saw the deceased alive on July , 19 56 , and that death occurred at 4 1/2 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Charles R. Williams M.D.				ADDRESS (Street, city or town, state) Emmitsburg, Md.		DATE SIGNED Aug 2, 1956	
PHYSICIAN'S NAME (Type) Charles R. Williams MD							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 5, 1956		22c. NAME OF CEMETERY OR CREMATORY Keysville Cemetery		22d. LOCATION (City, town, or county) (State) Keysville, Carroll Co, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE S. L. Allison				ADDRESS Emmitsburg, Md.		24a. REC'D BY REGISTRAR AUG 5 1956	
				24b. REGISTRAR'S SIGNATURE A. H. Hendrich			

BUREAU V. 8

AUG 5 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08306

8332

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jefferson		c. LENGTH OF STAY IN 1b 3 Months	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Middle Last MARY JANE REBECCA WHIPP		4. DATE OF DEATH Month Day Year August 23, 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER-MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 20 Sept 1858
9. AGE (In years last birthday) yrs. 97		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-work		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME David Myers		14. MOTHER'S MAIDEN NAME Susan Specht	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. J. Raymond Corun, Jefferson, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic myocarditis 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 10 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug 16 , to Aug 22 , 19 56 , that I last saw the deceased alive on Aug 22 , 19 56 , and that death occurred at 7:30 A. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE H. F. Kline		M.D. 7 N. Market St., Frederick, Md. 8/23/56	
PHYSICIAN'S NAME (Type) H. F. Kline, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 25 Aug 1956	
22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		ADDRESS Frederick, Maryland	
24a. REC'D BY REGISTRAR 54 Aug 1956		24b. REGISTRAR'S SIGNATURE Elizabeth G. Heck	

CERTIFICATE OF DEATH

151

NAME OF DECEASED FREDERICK		DATE OF BIRTH JAN 1 1901		PLACE OF BIRTH BALTIMORE, MARYLAND	
SEX MALE		RACE WHITE		EDUCATION HIGH SCHOOL	
OCCUPATION LABORER		MARRIAGE MARRIED		DATE OF MARRIAGE JAN 1 1925	
PLACE OF DEATH BALTIMORE, MARYLAND		DATE OF DEATH JAN 1 1956		CAUSE OF DEATH HEART DISEASE	
MANNER OF DEATH NATURAL		IMMEDIATE CAUSE CORONARY THROMBOSIS		MEDICAL HISTORY HYPERTENSION	
PREVIOUS ILLNESS NONE		DATE OF ONSET JAN 1 1956		TREATMENT NONE	
PLACE OF INTERMENT BALTIMORE, MARYLAND		DATE OF INTERMENT JAN 1 1956		NAME OF FUNERAL HOME JOHN J. HARRIS	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	

BUREAU V. 2

JAN 27 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8310

CERTIFICATE OF DEATH

Reg. Dist. No. 131

08308

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick				c. LENGTH OF STAY IN 1b 11 wk.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 108 W. All Saints Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Ethel Middle Williams Last Williams				4. DATE OF DEATH Month August Day 11 Year 1956			
5. SEX Female		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 22-1903	
9. AGE (In years last birthday) yrs. 52		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY *****		11. BIRTHPLACE (State or foreign country) Frederick, Co.	
13. FATHER'S NAME John Tyler				14. MOTHER'S MAIDEN NAME Vergie Davis			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Daniel Williams Address 108 W. All Saints St.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Uterus 174x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH Years							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from July 21, 1953 , to Aug. 11, 1956 , that I last saw the deceased alive on Aug. 9, 1956 , and that death occurred at 4:00 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 7 East Church Street Frederick, Md. DATE SIGNED Robert S. Turner, Jr. ACTUAL SIGNATURE Robert S. Turner, Jr. M.D. PHYSICIAN'S NAME (Type) R.S. Turner Jr.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 14, 1956		22c. NAME OF CEMETERY OR CREMATORY Bartonsville		22d. LOCATION (City, town, or county) (State) Frederick-Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles E. Hicks III ADDRESS Frederick, Md.				24a. REC'D BY REGISTRAR DATE 14 Aug 1956		24b. REGISTRAR'S SIGNATURE Elizabeth G. Heck	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. Name of deceased: John T. Smith</p>		<p>2. Sex: Male</p>	
<p>3. Date of birth: 1915-03-15</p>		<p>4. Place of birth: Baltimore, Md.</p>	
<p>5. Date of death: 1956-08-15</p>		<p>6. Place of death: Baltimore, Md.</p>	
<p>7. Cause of death: Heart Disease</p>		<p>8. Manner of death: Natural</p>	
<p>9. Signature of physician: Dr. J. H. Smith</p>		<p>10. Signature of registrar: John T. Smith</p>	
<p>11. Date of registration: 1956-08-15</p>		<p>12. Place of registration: Baltimore, Md.</p>	
<p>13. Name of informant: John T. Smith</p>		<p>14. Address of informant: 1234 Main St., Baltimore, Md.</p>	
<p>15. Name of informant: John T. Smith</p>		<p>16. Address of informant: 1234 Main St., Baltimore, Md.</p>	
<p>17. Name of informant: John T. Smith</p>		<p>18. Address of informant: 1234 Main St., Baltimore, Md.</p>	
<p>19. Name of informant: John T. Smith</p>		<p>20. Address of informant: 1234 Main St., Baltimore, Md.</p>	
<p>21. Name of informant: John T. Smith</p>		<p>22. Address of informant: 1234 Main St., Baltimore, Md.</p>	
<p>23. Name of informant: John T. Smith</p>		<p>24. Address of informant: 1234 Main St., Baltimore, Md.</p>	
<p>25. Name of informant: John T. Smith</p>		<p>26. Address of informant: 1234 Main St., Baltimore, Md.</p>	
<p>27. Name of informant: John T. Smith</p>		<p>28. Address of informant: 1234 Main St., Baltimore, Md.</p>	
<p>29. Name of informant: John T. Smith</p>		<p>30. Address of informant: 1234 Main St., Baltimore, Md.</p>	
<p>31. Name of informant: John T. Smith</p>		<p>32. Address of informant: 1234 Main St., Baltimore, Md.</p>	
<p>33. Name of informant: John T. Smith</p>		<p>34. Address of informant: 1234 Main St., Baltimore, Md.</p>	
<p>35. Name of informant: John T. Smith</p>		<p>36. Address of informant: 1234 Main St., Baltimore, Md.</p>	
<p>37. Name of informant: John T. Smith</p>		<p>38. Address of informant: 1234 Main St., Baltimore, Md.</p>	
<p>39. Name of informant: John T. Smith</p>		<p>40. Address of informant: 1234 Main St., Baltimore, Md.</p>	
<p>41. Name of informant: John T. Smith</p>		<p>42. Address of informant: 1234 Main St., Baltimore, Md.</p>	
<p>43. Name of informant: John T. Smith</p>		<p>44. Address of informant: 1234 Main St., Baltimore, Md.</p>	
<p>45. Name of informant: John T. Smith</p>		<p>46. Address of informant: 1234 Main St., Baltimore, Md.</p>	
<p>47. Name of informant: John T. Smith</p>		<p>48. Address of informant: 1234 Main St., Baltimore, Md.</p>	
<p>49. Name of informant: John T. Smith</p>		<p>50. Address of informant: 1234 Main St., Baltimore, Md.</p>	
<p>51. Name of informant: John T. Smith</p>		<p>52. Address of informant: 1234 Main St., Baltimore, Md.</p>	
<p>53. Name of informant: John T. Smith</p>		<p>54. Address of informant: 1234 Main St., Baltimore, Md.</p>	
<p>55. Name of informant: John T. Smith</p>		<p>56. Address of informant: 1234 Main St., Baltimore, Md.</p>	
<p>57. Name of informant: John T. Smith</p>		<p>58. Address of informant: 1234 Main St., Baltimore, Md.</p>	
<p>59. Name of informant: John T. Smith</p>		<p>60. Address of informant: 1234 Main St., Baltimore, Md.</p>	
<p>61. Name of informant: John T. Smith</p>		<p>62. Address of informant: 1234 Main St., Baltimore, Md.</p>	
<p>63. Name of informant: John T. Smith</p>		<p>64. Address of informant: 1234 Main St., Baltimore, Md.</p>	
<p>65. Name of informant: John T. Smith</p>		<p>66. Address of informant: 1234 Main St., Baltimore, Md.</p>	
<p>67. Name of informant: John T. Smith</p>		<p>68. Address of informant: 1234 Main St., Baltimore, Md.</p>	
<p>69. Name of informant: John T. Smith</p>		<p>70. Address of informant: 1234 Main St., Baltimore, Md.</p>	
<p>71. Name of informant: John T. Smith</p>		<p>72. Address of informant: 1234 Main St., Baltimore, Md.</p>	
<p>73. Name of informant: John T. Smith</p>		<p>74. Address of informant: 1234 Main St., Baltimore, Md.</p>	
<p>75. Name of informant: John T. Smith</p>		<p>76. Address of informant: 1234 Main St., Baltimore, Md.</p>	
<p>77. Name of informant: John T. Smith</p>		<p>78. Address of informant: 1234 Main St., Baltimore, Md.</p>	
<p>79. Name of informant: John T. Smith</p>		<p>80. Address of informant: 1234 Main St., Baltimore, Md.</p>	
<p>81. Name of informant: John T. Smith</p>		<p>82. Address of informant: 1234 Main St., Baltimore, Md.</p>	
<p>83. Name of informant: John T. Smith</p>		<p>84. Address of informant: 1234 Main St., Baltimore, Md.</p>	
<p>85. Name of informant: John T. Smith</p>		<p>86. Address of informant: 1234 Main St., Baltimore, Md.</p>	
<p>87. Name of informant: John T. Smith</p>		<p>88. Address of informant: 1234 Main St., Baltimore, Md.</p>	
<p>89. Name of informant: John T. Smith</p>		<p>90. Address of informant: 1234 Main St., Baltimore, Md.</p>	
<p>91. Name of informant: John T. Smith</p>		<p>92. Address of informant: 1234 Main St., Baltimore, Md.</p>	
<p>93. Name of informant: John T. Smith</p>		<p>94. Address of informant: 1234 Main St., Baltimore, Md.</p>	
<p>95. Name of informant: John T. Smith</p>		<p>96. Address of informant: 1234 Main St., Baltimore, Md.</p>	
<p>97. Name of informant: John T. Smith</p>		<p>98. Address of informant: 1234 Main St., Baltimore, Md.</p>	
<p>99. Name of informant: John T. Smith</p>		<p>100. Address of informant: 1234 Main St., Baltimore, Md.</p>	

AUG 15 1956

BUREAU V. S.

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8311

CERTIFICATE OF DEATH

08309

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>FREDERICK</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>FREDERICK</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FREDERICK</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>FREDERICK Memorial Hospital</u>				d. STREET ADDRESS <u>Rte #1</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Philip</u> Middle <u>Joseph</u> Last <u>WOLFE</u>				4. DATE OF DEATH Month <u>August</u> Day <u>10</u> Year <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>August 9, 1956</u>	
9. AGE (In years last birthday) yrs. <u>14</u>		IF UNDER 1 YEAR Months <u>14</u> Days <u>15</u>		IF UNDER 24 HRS. Hours <u>14</u> Min. <u>15</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>AMERICAN</u>							
13. FATHER'S NAME <u>Philip Joseph Wolfe Jr.</u>				14. MOTHER'S MAIDEN NAME <u>Clara Elaine Bawie</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Pl #1 Mother - Mrs. Clara Wolfe Dickerson</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral anoxia</u> 761.0 DUE TO <u>total atelectasis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>(Placenta praevia marginalis)</u> DUE TO <u>Maternal</u> (c) <u>Maternal</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Aug. 9</u> , 19 <u>56</u> , to <u>Aug. 10</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Aug. 10</u> , 19 <u>56</u> , and that death occurred at <u>11:57 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>B.O. Thomas Jr.</u> M.D.				ADDRESS (Street, city or town, state) <u>FREDERICK Md</u> DATE SIGNED <u>Aug. 10, 1956</u>			
PHYSICIAN'S NAME (Type) <u>B.O. Thomas Jr.</u>				FREDERICK MARYLAND			
22a. BURIAL CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>8/12/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Pells Chapel</u>		22d. LOCATION (City, town, or county) (State) <u>Dickerson, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Snowden</u> ADDRESS				24a. REC'D BY REGISTRAR <u>Aug. 16, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Ely G. Zecher</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

AUG 16 1956

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

8333

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cullen, Maryland				c. LENGTH OF STAY IN 1b 42 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Victor Cullen State Hospital				d. STREET ADDRESS 21X-2			
3. NAME OF DECEASED (Type or print) First Harry Middle P. Last Zulauf				4. DATE OF DEATH Month August Day 27 Year 19 56			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 9, 1900		9. AGE (In years last birthday) 55 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hotel Clerk		10b. KIND OF BUSINESS OR INDUSTRY Dagmar Hotel		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Harry C. Zulauf				14. MOTHER'S MAIDEN NAME Mary Pasquay			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 212-07-7824		17. INFORMANT Deceased		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolism DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Thrombophlebitis DUE TO (c) Pulmonary Tuberculosis						INTERVAL BETWEEN ONSET AND DEATH 5 minutes 2 weeks 4 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 16 , 19 56 , to August 27 , 19 56 , that I last saw the deceased alive on August 27 , 19 56 , and that death occurred at 4:30 P. M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>I. B. Lyon</i>				ADDRESS (Street, city or town, state) Cullen, Maryland		DATE SIGNED August 27, 1956	
PHYSICIAN'S NAME (Type) I. B. Lyon, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Wm. Saunders</i>				ADDRESS <i>Baltimore, Md.</i>		24a. REC'D BY REGISTRAR DATE 8/28/56	
				24b. REGISTRAR'S SIGNATURE <i>Wm. Saunders</i>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours of death. Page 4.

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

